The profile of HIV and Aids-related stigma and discrimination within a company in Maputo

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DECLARATION

I the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Signature:

Date:

ABSTRACT

The present article is a research study aimed at providing an accurate picture of the problem of HIV and Aids-related stigma and discrimination within a company, by identifying the possible factors that help fuelling it, and describing the relationships among them.

On the basis of these findings, I propose initiatives that may help to overcome the main barriers for stigma mitigation within the company, and provide suggestions for inclusion in the company's HIV and Aids policy of strategies and positions that may thwart stigma among the workforce.

OPSOMMING

Die doel van hierdie studie was om ‘n akkurate beskrywing te gee van stigma en diskriminasie wat romdon MIV/Vigs bestaan. Die studie is in ‘n maatskappy in Maputo, Mosambiek, uitgevoer.

Moontlike faktore wat hierdie stigma en diskriminasie aanwakker is gegee en ook die verhouding tussen die faktore. Voorstelle word gegee om stigma binne die maatskappy te verminder en ook om dit by die maatskappy se MIV/Vigs beleid in te sluit.

ACRONYMS

Aids	Acquired Immunodeficiency Syndrome
ARVs	Antiretrovirals
GIPA	Greater Involvement of People living with or affected by HIV and Aids
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
PLWHAs	People Living With HIV and Aids
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

"Stigma and discrimination associated with HIV and Aids are the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating impact. They are triggered by many forces, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment, irresponsible media reporting on the epidemic, the fact that Aids is incurable, social fears about sexuality, and fears relating to illness and death."

(UNAIDS, 2002)

Introduction

Stigma and discrimination are recognized as major factors fuelling the spread of the HIV epidemic. Stigma creates a climate of fear and ignorance and discourages confronting the growing infection rates. It is widely acknowledged that it is important to address the HIV and Aids-related stigma in order to improve the quality of the lives of people living with HIV and Aids and to address prevention effectively (Siyam'kela, 2003). Stigma also influences the way we respond to the HIV and Aids epidemic.

Stigma is at the origin of the association of the HIV with punishment due to bad behaviour, rejection of testing, the hiding of positive results and illnesses, self-imposed isolation, and denial for fear of being rejected by close family and friends.

Stigma, the "third epidemic" (further to the HIV epidemic and the Aids epidemic) as it was named by Dr Jonathan Mann, founder of the World Health Organization's Global Programme on Aids (Mann, 1987), is a challenge to our compassion, our judgment and our humanity.

Some companies have implemented non-discriminatory policies and HIV and Aids prevention and treatment programs for their workers. Not unusually however, these efforts turn to be unsuccessful, because of HIV and Aids-related stigma prevailing among workers and communities.

The workplace HIV and Aids services now increasingly provided by companies to their employees are often underutilized because employees fear stigma and discrimination. It is common to find that many workers are discouraged from being

tested for HIV for instance, and stigma may also prevent them and their families from getting the HIV and Aids benefits offered by companies (Hadjipateras, 2004).

There are anecdotal descriptions of employees that have died of Aids although they were entitled to free HIV and Aids treatment in their companies. Fear of social isolation and ridicule is what discourages workers from disclosing their sero-status and using workplace HIV and Aids services (Williams et al, 2004).

In fact, 'finger-pointing' moralistic attitudes, compounded by ignorance, create a hostile environment and act as a strong disincentive for employees to claim their rights. People living with HIV and Aids (PLWHAs) have become targets for blame and punishment. This heightens their vulnerability to HIV and Aids and pushes them into a vicious cycle of stigmatisation and discrimination.

A recent study in South Africa (Siyam'kela, 2003) implemented among PLWHAs, revealed the importance of acceptance of PLWHAs by their family, faith group, friends and colleagues in helping them to overcome the initial shock of discovering their status, eventually learning to accept it and live positively. Where PLWHAs have not been able to find such support, they have also been more likely to internalise societal stigma.

An HIV and Aids-friendly workplace environment

There have been few workplace interventions aimed specifically at reducing stigma or creating support for workers who are HIV-positive. This is usually due to the difficulty of designing and evaluating these interventions, because of the uncertainty about how to define and measure the complex process of stigmatization.

Combating stigma is a crucial determinant of the success of any HIV workplace policy. As such, awareness-raising and education for all staff, is the first priority to be addressed. Besides formal policies, it is important to provide spaces for frank discussion and airing of views as a means of creating an open and supportive work

environment (Hadjipateras, 2004). The aim is to create a stigma-free working environment and mitigate the impact of HIV and Aids on staff.

Eskom's recent study on stigma also corroborates this view on the importance of creating a favourable workplace environment for promoting acceptance of PLWHAs (Williams et al, 2004).

However, managers and trade unions seem not to be aware of this. In fact, a recent survey among 383 workplaces in South Africa, showed that 89% of the managers and 91% of the trade unions leaders considered that stigma and discrimination was not a problem for their workplaces (Stevens, 2004).

Stigma remains the main factor as to why HIV and Aids workplace programs are not going smoothly. Hopefully this situation will change, as myths are destroyed and as the process of time allows for acceptance of the fact that everyone is vulnerable to this disease regardless of their sex lives, religion, and status in the community (Reed, 2004).

Survey of staff views and attitudes

It is important to find the reasons for the low uptake of the HIV and Aids benefits offered to employees. Stigma probably plays an important role in this. A survey of staff attitudes may help revealing these reasons, as well as pointing to possible responses. It is a valuable way of recognizing differences and promoting a constructive process of attempting to address and resolve them (Hadjipateras, 2004).

Before planning an intervention to address stigma, Siyam'kela (2003) suggests that a stigma audit is conducted to assess the extent of the problem, as well as the local barriers and enhancing factors of stigma mitigation. This may include a survey of employees to assess their perceptions of PLWHAs and how these perceptions have influenced their responses to PLWHAs.

The audit will allow decision-makers to assess the extent of stigma and to identify the critical issues within the company that need to be addressed as well as the main barriers for stigma mitigation.

Research objectives

In order to address workplace stigma and discrimination effectively, we must better understand the causes, manifestations and consequences of work environment stigma and how these translate into discriminatory behaviours.

The objective of this descriptive type of research is to provide an accurate picture of the problem of HIV and Aids-related stigma and discrimination within a company with 190 workers based in Maputo, by identifying the possible factors that help fuelling it, and describing the relationships among them.

The research question can thus be phrased as follows:
"What are the main factors contributing to the HIV and Aids-related stigma and discrimination within the company's workforce as well as the possible relationships among them?"

Research problem

The research problem is initiated by the occurrence of discriminatory attitudes and behaviours within the company's workforce, and my hypothesis is the following:

"Lack of knowledge of basic facts about HIV and Aids as well as fear, denial, and contempt are important factors fuelling the occurrence of stigma and discrimination within the company's workforce, and their extent varies according to different variables such the worker's age, gender and professional level."

Research methodology

Research design

I used a survey design, a non-experimental research technique. A questionnaire was administered to a representative sample of the company's workforce through direct contact, so as to assess their characteristics, behaviours and attitudes that are relevant to the investigation. It is a quantitative study to examine the issue of HIV and Aids-related stigma and discrimination among employees of the company.

Sampling

The company's human resources department is equipped with a management information system that includes a listing of all employees. This listing represents a sampling frame that has allowed using a probability sampling technique involving random selection procedures to ensure that all subjects of the population in the study will have an equal chance of being included in the sample. In this way, external validity or generalizability of the results of the study is maximized.

Given that the total population in the company is 190 subjects, a sample size of 64 subjects representing roughly one third of that population was used. I used a systematic sampling method. Thus, subjects were selected from the sampling frame at regular intervals. Because our sample represented one third of the number of subjects, the regular interval was every-other-two (sampling fraction), i.e. 1 in 3. To make the decision where to start this selection, a random procedure by lottery was used.

Data gathering

For data gathering, a structured questionnaire with 44 closed ended questions was used as the research instrument of the survey (Annex I). The questionnaire was anonymous, and respondents were ensured that their confidentiality and privacy would always be protected. The questionnaire was administered using the face-to-face method instead of being self-administered, in view of the high proportion of employees with minimal education. The questionnaire was previously pre-tested, and errors detected were

corrected. To ensure the quality of data collected, interviewers were extensively trained in the administration of the questionnaires.

Data processing

Data was entered on a software program EpiData and then analysed on a software program SPSS. I compared the frequency distribution of each of the identified independent variables for each of those that completed the questionnaire. Information on relationships between two or more variables was captured through cross-tabulations. Statistically significant differences were confirmed by a statistical test, Chi-square. The results obtained on the basis of the sample used were calculated with a 95% confidence interval so as to allow extrapolation to the entire workforce.

Results

Respondents' Background

Age and sex

The ages of the 64 employees that responded to the questionnaire, ranged from 21 years to 61 years. The majority was between 30 and 39 years old (65%). Twenty six per cent of them were 40 years and older, while only 7.8% was between 20 and 29 years old.

Table 1 – Age distribution of respondents

Age groups	Frequency	%
20 - 29	5	7,8
30 - 39	42	65,6
40 - 49	15	23,4
50 +	2	3,1
Total	64	100,0

Females represented 20% (13/64) of the respondents, similarly to their gender distribution in the company's universe (23% = 44/190).

Professional level

The majority of the respondents (40%) were unskilled workers (*Agente serviço, Operário, and Auxiliar administrativo*). Thirty seven per cent were skilled workers (*Técnico Superior*), and 22% were semi-skilled workers (*Assistente Técnico and Técnico professional).* Table 2 shows their representativity when compared to the company's universe.

Table 2 – Professional level of respondents and their correspondent proportionality in the company's universe

Professional level	Respondents		Company's Universe	
	n	%	n	%
Unskilled	26	40.6	71	37.3
Semi-skilled	14	21.8	42	22.1
Skilled	24	37.5	77	40.5
Total	64	100	190	100

These professional levels – unskilled, semi-skilled, and skilled – generally correspond to levels of education/schooling of standard 1st-12th, standard 12th, and university degree, respectively.

Social life

Sexual partner

Nearly all the respondents have a spouse (71.9%), permanent partner (7.8%) or girl/boyfriend (20.3%). Only two (3.1%) have no fixed partner. Two have more than one partner.

Children

Ten respondents had no children. All the others had between one and eight children, with an average of 2.3 children per respondent.

Living in Maputo

Most respondents were born in Maputo and always lived here, or live continuously in Maputo for more than five years. Only 11% of the respondents have lived continuously in Maputo for less than five years.

Cohabitation

The number of people cohabiting with the respondents varied from one to 16, with an average of 5.3 people per respondent.

Years working at the company

Half the respondents (32/64) work for the company for more than ten years. Those who work for less than five years account for 14% (9/64).

Stigma and Discrimination

To know someone who has had a blood test for HIV and Aids and is positive

Less than half the respondents (44%), (28/64) claimed to know someone who has had a blood test for HIV and Aids and is positive.

Table 3 – Respondents that know someone who has had a blood test for HIV and Aids and is positive, distributed by professional level (n = 28 = 44% of the total)

Professional level	Total	Frequency	%
Unskilled	26	12	46
Semi-skilled	14	7	50
Skilled	24	9	37,5
Total	64	28	44

As shown in Table 3, when breaking down respondents by their professional level, skilled workers are proportionally less represented (37.5%) when compared to unskilled and semi-skilled workers (46% and 50%, respectively). However, this difference is not statistically significant.

Concerning gender, women knew significantly more HIV-positive people (61.5%) than men (39.2%) (p = 0.03). In terms of age, respondents aged 30-39 years knew significantly more HIV-positive people (52%) than the other age groups. In fact, respondents aged 20-29 years account for 40%, and those aged 40 and more years were less than 30% (p = 0.01) (Table 4).

Table 4 - Respondents that know someone who has had a blood test for HIV and Aids and is positive, distributed by age group (n = 28 = 44% of the total)

Age groups (years)	Total	Yes	
		n	%
20-29	5	2	40
30-39	42	22	52
40-49	15	4	27
50+	2	0	0
Total	64	28	44

Data above supports the suspicion that disclosure is limited, given that so many people claimed not to know of anyone with HIV and Aids. This makes it difficult to assess the levels of stigmatisation within the workplace. Also, it suggests that it is important to involve PLWHAs in the activities of this company's HIV and Aids programme. This can be a strong disincentive for discrimination.

According to the results above, the main targets of this initiative for interaction with PLWHAs at this company should be especially men. Women and workers aged 30-39 years, should be actively involved for supporting this plan, given their higher knowledge of PLWHAs.

Disclosure

> "Let us give publicity to HIV and Aids and not hide it, because the only way to make it appear like a normal illness is always to come out and to say somebody has died because of HIV and Aids. And people will stop regarding it as something extraordinary."
> *Nelson Mandela, disclosing that Aids was the cause of his son's death. January, 2005.*

Respondents were asked whether or not they think it is important to tell other people if they discover they are HIV positive or have Aids. Those who did think it is important were then asked whom they would tell, and how they would go about the process of telling another person.

Nearly half (44%) the respondents said they think it is not important to inform others (14/64), or they did not know (14/64). Those who think it is important to tell other people if they discover they are HIV positive or have Aids represent 56% (36/64). No significant differences were found concerning age, gender and professional level of the respondents.

When asked if a family member of the respondent got infected with HIV and Aids, would s/he want it to remain a secret, nearly half – 43.8% (28/64) – responded affirmatively. The percentage of those who did not know accounted for 6.3% (4/64). When crossing the variables age, gender and professional level of the respondents with this question, no significant differences were found.

At the individual level, more than 90% of the respondents (59/64) said they would reveal their HIV status to someone else in case they were infected with HIV. No significant differences were found related to professional level, gender and age.

Again, disclosure appears still limited, particularly at the community and family levels. Many respondents still believe there to be no point in telling others. This attitude is conducive to stigma internalization or 'felt stigmatisation'. Self-stigma incorporates feelings of shame, dejection, self doubt, guilt, self blame and inferiority. It leads to high levels of stress and anxiety, and to denial. Some people withdraw from society

and stop participating in normal social activities because of their lowered self-esteem and sense of self-worth. Some give up work and 'wait to die' (HDN Moderation Team, 2004).

In fact, some people seem to prefer living with the burden of their secret, rather than looking for support from friends or seeking medical care. This is probably contributing to the low uptake of voluntary testing offered by the company, since there can appear to be little to gain from coming forward to be tested. And an awful lot to lose if the result is positive: ostracism, ridicule and discrimination are powerful disincentives (Irin Plus News, 2004).

When asked if "a person should only tell others that they have HIV and Aids when they are sick and have no choice", around 19% of the respondents agreed (5%), or "don't know" (14%). This shows that even with the recent developments in HIV and Aids treatment, resistance to disclosure is still important. Furthermore, it emphasizes the need for widespread information dissemination within the company's staff on the importance of seeking treatment in the early stages of the infection.

Whom to and how to tell

Among the 60 respondents who said they would reveal their HIV status, more than 80% (49/60) said that they would tell first to their sexual partner (spouse, permanent partner or girl/boyfriend) while the rest mentioned Mother/Father (13%) or other close relative(s) (3%). Only five of these 60 respondents said they would not reveal their HIV status to someone else, or they did not know.

Concerning the method of disclosing their positive status to their partners, the majority favoured telling them of the infection after the creation of an adequate environment such as a place that is quiet and calm. Some said they would suggest that the partner should go for a test. Around 15% (10/64) of the respondents said they would just show the results of the HIV test. Two respondents said they would invite the partner to go for a test together.

It is worth mentioning that outside support from churches or counsellors was not seen as important when telling others of one's status, contrary to the findings of other studies (DRA-development, 2001).

Interacting with PLWHAs

When asked if they would feel comfortable to interact with PLWHAS in different ways, such as shaking hands, eating from the same plate, sharing work tools, sharing the same toilet, or travelling in the same vehicle, respondents' answers were as shown in Table 5.

Table 5 – Respondent's answers about interaction with PLWHAS in different ways (frequency) n = 64

Would you feel comfortable to:		Yes		No	Maybe
		n	%		
▪ shake hands	with a colleague / person whom you know has HIV and Aids?	62	97	1	1
▪ eat from the same plate		45	70	11	8
▪ share work tools		62	97	1	1
▪ share the same toilet		58	90	4	2
▪ travel in the same vehicle		63	98	1	0

Eating from the same plate

"Eating from the same plate" is the interaction with PLWHAs that is feared by most respondents (30%). More skilled workers (75% of them) than other workers (64% for semi-skilled and 69% for unskilled) feel comfortable to eating from the same plate. Similarly, more men (72.5%) than women (61%) feel comfortable to eating from the same plate. These two differences however, are not statistically significant.

Sharing the same toilet

"Sharing the same toilet" is still a concern for 10% of the respondents. No significant differences were found concerning "sharing the same toilet", in terms of gender, age or professional level.

Nearly all respondents feel comfortable to interact with PLWHAS in other ways such as shaking hands, sharing work tools, or travelling in the same vehicle.

The above results reveal a considerable lack of knowledge about the means of transmission of HIV. An inadequate understanding of the way HIV transmission can take place leads to fear of transmission through casual contact. This suggests the need to strengthen this area of knowledge in the information and communication activities that are planned to be addressed to staff within the company.

Separation and isolation

More than 90% of the respondents (59/64) reject that colleagues/people with HIV and Aids should be separated from others revealing a wide general acceptance of PLWHAs. However, there are still a few respondents who agree with this or don't know. Most of them are unskilled workers.

On the contrary however, nearly 60% of the respondents (38/64) agree that "if I had HIV and Aids, people would avoid me", and 26.6% (17/64) don't know. Women are significantly represented among these when compared with men ($p = 0.01$).

Only 8% (5/64) agree that "if I sit near someone with HIV and Aids, others will think that I have HIV and Aids too", while 80% (51/64) disagree. Thus, "secondary stigma" generated by proximity and association, seems not to be significant.

Bad treatment of PLWHAs

Isolation, rejection and rumours/gossip were the kinds of bad treatment respondents think PLWHAs and/or their families usually face, as shown in Table 6.

Table 6 - The kinds of bad treatment respondents think PLWHAs and/or their families usually face

Kinds of bad treatment	Frequency	%
Isolation	55	85,9
Rejection	33	51,6
Rumours/gossips	20	31,3
Verbal abuse	6	9,4
Ejection from home	4	6,3
Rejection by community	2	3,1
Physical abuse/violence	1	1,6
None	1	1,6
Other	3	4,7

This finding is slightly different from that reached in a similar study in South Africa at Eskom where gossip and rumours were found as the most common form of stigmatisation (DRA-development, 2001).

Gossip and rumours

When checking their perceptions on how they would be treated, 66% of the respondents (42/64) think that "if I had HIV and Aids, people would call me names and gossip about me". Twenty three per cent (15/64) said they did not know. Only 11% (7/64) disagreed that they would be gossiped about if they had HIV and Aids.

This result corroborates the suspicion that gossip is a common form of stigmatisation, and points to the workers' frustration with the suspicion and gossip that is present in their everyday life. On the other hand, this causes greater isolation and self-stigma perpetuating a reinforcing cycle.

Treatment of PLWHAs and/or their families

Respondents think that those who treat PLWHAs and/or their families badly are essentially neighbours, family members, friends and colleagues, in this order of frequency, as illustrated in Table 7.

Table 7 - Those who treat PLWHAs and/or their families badly

Those who treat badly	Frequency	%
Neighbours	39	60,9
Family members	36	56,3
Friends	28	43,8
Colleagues	26	40,6
Everyone	3	4,7
Community members	3	4,7
Health workers	2	3,1
Young people	2	3,1
Religious groups	0	0
Other	4	6,2

It is surprising that bad treatment of PLWHAs by health workers was mentioned by two respondents only, particularly when it is known that discrimination in health care settings is common in Mozambique (Kindlimuka, 2001).

Treatment of PLWHAS' families

Nearly half the respondents (44%) think that the families who have lost a member to Aids are treated worse than those who have lost a member to other causes. Thirty six per cent (23/64) think they are treated the same, while 17% (11/64) said they don't know. This supports the evidence of strongly perceived HIV and Aids-related stigma within the company.

Caring for PLWHAs

The majority (62.5%) think PLWHAs should get the same health care as someone with another chronic disease/illness, and 37% thought they should get more health care. None had the opinion that PLWHAs should get less health care.

There was ample agreement that "I would be willing to care for a male/female relative with Aids in my house". Only one respondent disagreed to care for a female relative. It is interesting to note that women were significantly more willing than men to care for a male relative with Aids ($p = 0.03$). Concerning caring for a female relative with Aids however, there was no significant difference related to gender.

These results express attitudes of sympathy and compassion for PLWHAs that should be explored and encouraged for the building up of a HIV and Aids-friendly environment within the company.

PLWHAs at work

Only one respondent agreed that if a colleague is found to be infected with HIV and Aids, s/he should not continue working. Another three said they did not know.

Two respondents agreed that "a person who has HIV and Aids should not be allowed to work" and one did not know. They are all unskilled workers. This result confirms the suspicion that there are still people who have misconceptions and myths surrounding basic facts such as this. This means that current plans to expose staff to more detailed and deeper knowledge on HIV and Aids still need to be coupled with information and education on basic knowledge.

PLWHAs' gender

When asked if a woman infected with HIV is treated better, the same, or worse than an infected man, 39.1% (25/64) of the respondents said they are treated the same (Table 8).

Table 8 – "Is a woman infected with HIV treated better, the same, or worse than an infected man?"- Respondents' opinions, by gender

Is a woman infected with HIV treated better, same, or worse than an infected man?	Male		Female		Total	
	n	%	n	%	n	%
Better	7	13.7	0	0	7	10.9
The same	21	41.2	4	30.9	25	39.1
Worse	8	15.6	8	61.5	16	25
Don't know	15	29.5	1	7.6	16	25
Total	51	100	13	100	64	100

Considering those who think a woman infected with HIV is treated worse, a highly significant statistical difference was found: 61.5% of the female respondents (8/13) did think so, while only 15.6% of the male respondents (8/51) did ($p = 0.005$).

This remarkable disparity is probably the result of the gender inequities so common within the conservative Mozambican society. This finding ought to be born in mind whenever designing stigma mitigation strategies for the company.

Twenty five percent of the respondents (15 men and one woman) said they did not know if a woman infected with HIV is treated better, same, or worse than an infected man. Only 10.9% (7/64) said a woman is treated better, and these were all male. This seems to reinforce the above-mentioned disparity.

PLWHAs selling food

Surprisingly, nearly half (46.8%) the respondents agree with the statement that "a person who has HIV and Aids should not be allowed to sell food" (25%), or they "don't know" about it (21.9%). Unskilled workers accounted for significantly more of these (65.3%) when compared with other workers ($p = 0.005$) (Table 9).

Table 9 - "A person who has HIV and Aids should not be allowed to sell food" – Respondents' opinions ("agree" and "don't know"), by professional level

Professional level	Total	Agree		Don't know		Total Agree/don't know	
		n	%	n	%	n	%
Unskilled	26	13	50	4	15.4	17	65.3
Semi-skilled	14	1	7.1	3	21.4	4	28.5
Skilled	24	2	8.3	7	29.2	9	37.5
Total	64	16	25	14	21.9	30	46.8

Again, an important lack of knowledge regarding the means of transmission of HIV and Aids is evident, particularly among unskilled workers. In fact, PLWHAs are wrongly perceived as being a threat to public health.

Aids as a punishment

Nearly one fourth of the respondents (15.6%) agreed that "HIV and Aids is a punishment for bad behaviour", while 14.1% did not know, accounting for a total of 29.6% (19/64) of all respondents. When broken down by professional level, unskilled workers are significantly more represented (50%) than other workers (14.2% and 16.6% of the semi-skilled and skilled workers, respectively) (p= 0.03) (Table 10). These results show stigma being generated because the mode of transmission of the infection is wrongly perceived to be under the control of individual behaviour. As expected, unskilled workers significantly outnumber other workers in terms of this wrong perception. On the other hand, women again reveal a clearer perception of HIV and Aids-related basic facts: in fact, when considering the respondents' gender in relation to this statement, not a single woman (0/13) agreed, or said she did not know about this statement, while the corresponding figure for men accounted for 37.2% (p = 0.03).

Table 10 - "HIV and Aids is a punishment for bad behaviour" – respondents opinions ("agree" and "don't know"), by professional level

Professional level	Total	Agree		Don't know		Total Agree/don't know	
		n	%	n	%	n	%
Unskilled	26	8	30.7	5	19.2	13	50
Semi-skilled	14	0	0	2	14.24	2	14.2
Skilled	24	2	8.3	2	8.3	4	16.6
Total	64	10	15.6	9	14.1	19	29.6

PLWHAs are often thought of as being responsible for becoming infected. These beliefs are usually built on religious or moral values that lead some people to think that having HIV and Aids is the result of a moral fault (such as "promiscuity" or 'deviant sex') that deserves punishment.

Deserted by partner

When asked "if you tell your regular partner that you have HIV and Aids, s/he will leave you", nearly half the respondents (31/64) said they did not know. There is no significant difference concerning this opinion in terms of gender, age or professional level. Thirteen per cent of the workers (8/64) agreed on this. Again, no significant difference was found between different groups.

This result is impressive, and reveals how strong stigma and discrimination can be in relation to such a usually important, strong and long-lasting relationship. It shows also the need for promoting detailed HIV and Aids education among employees focusing on the absurdity of this attitude, and the enormous shared advantages that infected couples may gain by helping each other.

Fired from work

Eleven per cent of the respondents (7/64) agreed that "if I had HIV and Aids, my work would fire me", while 33% (21/64) did not know. Those who said they don't know are

predominantly younger workers, in the age group 20-29 (80% of them). Those aged 30-39, and 40 years and more are less represented (36% and 13%, respectively); this difference is statistically significant ($p = 0.02$), and this is not surprising since it is naturally expected that older employees feel safer about the security of their jobs than younger workers. No significant difference was found regarding gender or professional level. It can be envisaged how fearful these employees (43%) may be concerning losing their job, and how strongly this belief may act as a disincentive for testing and disclosure.

These findings reveal a wide lack of knowledge on the part of the respondents on their legal rights, including the Mozambique's law nr. 5/2002 of February 5 (Boletim da Republica, 2002) that states that no one should be discriminated against on the basis of their HIV status, and that all workers have equal opportunities. This law was passed by the Mozambique Parliament, and among other issues, prohibits the HIV status of an employee to be used as a criterion for promotion, access to training, eligibility to employee benefits, or dismissal. This law is applicable to all public and private sectors as well as the informal sector workers including domestic workers.

Conclusions and Recommendations

The information gathered has outlined current behavioural patterns and fears related to the stigma attached to PLWHAs. Ignorance, fear, shame, denial, and guilt, the main pillars of stigma, all show through many of the company's employees responses. It is apparent that, from the perspective of the respondents, stigmatisation and discrimination of PLWHAs is widespread.

In fact, many respondents claimed they expected to be isolated, excluded, abused, gossiped about, discriminated against, or rejected by neighbours, relatives, friends and workmates if they find themselves infected by HIV. They believe that their families would be embarrassed, and would try to conceal the infected person from the wider community. The general perception of respondents on the current practices is that PLWHAs' families are the target of bad treatment on the part of the society. Perceived

stigma thus revealed was similarly found in analogous studies at Daimler Chrysler South Africa and Eskom. (Becker, 2001; DRA-Development, 2001).

On the other hand however, most respondents reveal a sentiment of compassion for PLWHAs. In fact, almost every respondent expressed the individual view that PLWHAs should not be abused, deserved the same treatment as anyone else, and should not be isolated and excluded from society, and that their families deserve support and sympathy. Interestingly, the above-mentioned studies also report this apparent discrepancy (Becker, 2001; DRA-Development, 2001).

The rare exceptions to this compassionate attitude are unskilled workers. In general those few who more often demonstrate discriminatory attitudes are also unskilled workers.

These sentiments of sympathy and compassion for PLWHAs and an open position towards them is an appropriate background where most stigma mitigation initiatives should build upon within the company. For this, they need to be encouraged and supported. On the other hand, the company's employees need to be made aware that their perceptions on other people's views on PLWHAs are probably exaggerated.

It is evident that disclosure is limited within the company, particularly among men. It is apparent that there is very little open discussion and disclosure by those infected within the company. This paves the way for the promotion of myths and false values, thereby increasing the potential for stigmatisation. Self-isolation seems to be also an important contributor to limiting disclosure as it raises suspicions, gossip and rumours about the person. This in turn causes greater imposed and self-isolation.

When faced with the possibility that they are infected by HIV, workers largely considered sexual partners and close relatives as the main potential confidents. Different methods of disclosure were expressed, but outside support (churches, social workers, or counsellors) seems not to play a role at present. Many workers still believe there is no point in telling others their HIV status. Fear of bad treatment of PLWHAs

seems to be the main reason for this. HIV and Aids issues still remain largely hidden behind closed doors, perpetuating the fear and suspicion surrounding the disease.

In general, an important lack of knowledge regarding the means of transmission of HIV and Aids is evident. This occurs particularly among unskilled workers. Also, it is apparent that many workers and particularly those in the younger age group are not aware of their legal rights, namely in terms of their protection of not being fired, in case they get HIV infection.

Isolation, rejection and gossip and rumours are the main perceived stigmatising behaviours identified by respondents. Fear generated by HIV and Aids-related stigma and discrimination is evident as confirmed by a considerable part of the respondents that agree or don't know that "if you tell your regular partner that you have HIV and Aids, s/he will leave you". Female respondents showed a heightened perception of stigma when compared to male respondents.

Results obtained through this survey can help informing intervention activities designed to encourage disclosure and reduce stigmatisation of HIV and Aids within the company, employees' families and the broader community.

The recommendations below will hopefully help overcoming stigma and discrimination and in changing people's attitudes to Aids:

Workplace HIV and Aids policy

The workplace HIV and Aids policy should define the company's position and practices for handling HIV infection among employees. Creating an HIV and Aids-friendly environment and challenging the social acceptability of stigma should be the basis for this.

Elimination of stigma and discrimination on the basis of real or perceived HIV status is one of the four key areas of action to address HIV and Aids in the world of work

mentioned in the Code of practice of the International Labour Organisation (ILO) (du Toit and Burger, 2004). Thus, it is recommended that the company's policy defines a code of conduct along these same lines, a statement of good practice on the treatment of people living with and/or affected by HIV.

The company's HIV and Aids policy should specify that the HIV and Aids program to be implemented within the company needs to inform employees about their responsibilities, rights and expected behaviour at work. It should also aim at sustaining political commitment within management to improving the lives of PLWHAs, and strengthen PLWHAs support groups. The policy – that needs to be extensively discussed among all workers and management, and thoroughly publicised – should specify that it is expected that the programme may have direct influence on the employees' families as well as on the communities where employees come from.

Sufficient funding and resources must be allocated in a co-ordinated effort designed to encourage testing and disclosure, enhancing open debate, educating, and bringing the issue of HIV and Aids into the open.

The whole process needs to be led by management. For that, advocacy initiatives to sensitize them need to be envisaged, and respective guidance provided. It cannot be overemphasized that without commitment of the management, the program will be doomed to failure.

Contact with the stigmatized population

Staff knowing, meeting, and interacting with people who are living with HIV and Aids (PLWHAs) has proved an extremely effective way to overcome discriminatory attitudes among colleagues (Peter, 2004; Moyo, 2004). It is not possible to deal with stigma until we understand it, and education per se may not change attitudes. It is vital to involve positive people in all HIV and Aids interventions if they are to be successful (Yell, 2004). PLWHAs are obviously the most intimately affected by the HIV and Aids epidemic. Their personal experiences need to be translated into helping to shape a response to the epidemic.

For this, the principle of the Greater Involvement of People Living with or Affected by HIV and Aids (GIPA) is currently considered critical to ethical and effective responses to the epidemic (UNAIDS, 2002). This principle promotes a greater involvement of PLWHAs through an initiative to strengthen the capacity and coordination of networks of PLWHAs.

The implementation of policies of GIPA adds credibility to the HIV and Aids programs by giving a face to HIV and personalizing it. Also, it creates a supportive environment for PLWHAs and others to speak about HIV and Aids and issues related to it, and contribute towards a less stressed and more productive workforce. PLWHAs can add value to workplace HIV and Aids programs in a way that is relevant, effective, efficient, sustainable and ethical (UNAIDS, 2002).

On the face of the results obtained, the company should vigorously implement policies of GIPA. This means selecting members of PLWHAs support groups who are willing to speak publicly about their HIV status and to encourage open contact of employees with those infected by HIV and Aids. PLWHAs should also provide informal phone-in counselling and support services as well as providing formal pre- and post-test counselling. PLWHAs are in the best position to educate others as to how they got the disease, how it has affected them, and what they should do in the event of being infected themselves.

Policies of GIPA will be easier to implement if they are supported by workers. Given their detected higher knowledge of PLWHAs, women and workers aged 30-39 years in particular, should be actively involved in supporting this plan.

Knowledge and Education

Overcoming discriminatory attitudes requires many hours of education within the workplace, because it deals with changing deep-rooted attitudes, making stigma a

complex and devastating issue. The main task is to challenge fear-based messages and biased social attitudes (DRA-development, 2001).

There is an essential need for ongoing education on prevention, as well as coping strategies and mitigation. Information and education on basic knowledge about HIV and Aids is still very necessary. It is important to disseminate information among all employees on how to lead a productive life when HIV-positive, and about the recent developments on ARV treatment and their effects on the quality and longevity of PLWHAs.

In general, workers with lower schooling levels and lower socioeconomic status, especially unskilled workers, have shown to be the ones with sparser knowledge on HIV and Aids. They are also the ones who tend to face higher levels of stigma and discrimination. For that, they deserve special attention. A recent study found that, despite low levels of education and knowledge about HIV and Aids, most low socioeconomic status employees were found to be receptive to HIV and Aids prevention messages delivered at the workplace. It is likely that prevention messages focused on poorer employees will have a greater epidemiological impact than similar interventions conducted among employees of higher socioeconomic status (Macdowell, 2004).

The contents of educational initiatives should be suited to diverse levels of intervention according to the workers' professional level (skilled, semi-skilled and unskilled). They need to be standardised for each level. Relevant topics such as stigma, rights at the workplace, living positively, and treatment should be focussed through short-term "campaigns" (3-6 months) implemented jointly through different channels: written material (posters, leaflets, brochures, giant board), Peer Education (face-to-face and small groups sessions), and public addresses by managers.

These campaigns need to be phased and coordinated concentrating in specific topics at a time (e.g. basic knowledge on HIV transmission, ARV treatment and other care and support issues, Voluntary Counselling and Testing, etc.), so as not to divert attention to

many different HIV and Aids-related issues at the same time. Obviously, these campaigns need to be regularly repeated (e.g. annually) so as to produce the desired effect.

Time needs to be allocated for these activities during working hours, and educational campaigns should coincide with specific initiatives (e.g. mobilisation for Voluntary Counselling and Testing so as to provide them educational support. Given that the level of education of many staff is low, verbal as well as written materials are needed. Managers need to be involved in the educational process as this is encouraging for staff.

Disclosure

As shown by the results, there is little discussion and disclosure by those infected. "Secrecy exacts a toll on all involved. It eliminates any sharing of the burden; it prohibits being pro-active in learning and discussing; it discourages the seeking of care at an early stage; and it compromises finding the best treatment and staying the course" (Anderson, 2004). A lot of people around the world are facing "murderous prejudice" because of attitudes to their HIV status.

The impact of stigma can be enormous when it prevents going for a test and/or disclosing the results of a positive test. The consequences of not disclosing can ultimately be life-threatening. Sometimes the fear is incapacitating. The person must weigh the gains and the losses with disclosure. The problem becomes a vicious circle as inhibited disclosure and lack of exposure promotes myth and false belief, thereby increasing the potential of stigmatisation. Disclosure can be the difference between survival and death from the disease, between productive life and unproductive existence. Only those who disclose their status are able to seek treatment and care (Anderson, 2004).

The importance of disclosure can never be overemphasized. It facilitates access to care, because only those whose problems are known are likely to receive attention and assistance – antiretrovirals (ARVs), Voluntary Counselling and Testing

(VCT), treatment and prophylaxis for opportunistic infections, etc. It is important to reinforce the message that disclosing to select people could potentially save their life (if sexual partner), and also enable preparation and planning for a worst case scenario, thereby helping their children and family (DRA-development, 2001).

However, it cannot be ignored that the desired visibility of people with HIV and Aids as a 'normal' part of the society can only be achieved through the creation of an environment supportive for disclosure.

I recommend that workers be encouraged to get help from churches and religious groups to support disclosure. Religious congregations are among the main actors tackling HIV and Aids-related stigma and discrimination in Mozambique, urging their members to respect and support, showing love and compassion for PLWHAs (Taela, 2004).

Law 5/2002

The present research corroborates the view that many employees lack knowledge of their rights in society. They need to be educated, so they are able to challenge the stigma and discrimination they face in society. For this, the Law 5/2002 that prohibits workers' discrimination on the basis of their HIV status should be widely publicised and made known to all workers.

Legal processes can help in mitigating the worst effects of discrimination and stigma. However, they do not necessarily change mindsets nor do they guarantee a workplace free of stigma and discrimination. The law alone is not enough to combat HIV and Aids related discrimination. Fear and prejudice need to be simultaneously tackled at the community level.

Voluntary Counselling and Testing services

Voluntary Counselling and Testing (VCT) can play an instrumental role as part of the company's HIV and Aids program. However, because of stigma, people are reluctant

to reveal their status. Stigma and discrimination prevent people from being tested early and thus they do not receive the treatment they could have. Inability to inform others of one's status may deprive infected persons of the support and care of their family, and of the benefits of available information, support, counselling and treatment services.

For this, every effort must be made to encourage everyone to go for an HIV test. However, employees need to be made aware of the potential benefits and disadvantages of knowing their HIV status, and of disclosing their HIV status to employers, colleagues, families or friends. They need to assume that it is beneficial to them to use VCT to plan for theirs and their families' lives. They also need to be told about the potential emotional distress they may face as well as their families, friends and workmates, if they are found to be infected.

Testing has to be completely voluntary. Workers should be made aware that they are not legally obliged to disclose their HIV status to anyone. The issue of confidentiality should be discussed with workers, including that test results cannot be revealed to the employer without the employee's consent. To ensure confidentiality and to remove any stigma associated with "going for counselling", it is recommended to provide VCT services outside of the workplace. On-going counselling should be provided as is necessary for the employee. A counselling or referral service for family members, friends and colleagues should also be considered.

ARVs

Where treatment is not available, the motivation to go for testing is usually low, since many people feel the gains obtained through going for testing are not worthwhile. As such, it is recommended that the company provides effective HIV and Aids care and treatment including free anti-retroviral drugs for those infected as well as their relatives. Workers need to learn that they have choices for treatment and can enjoy healthier lifestyles, in case they are HIV-infected. Prevention and treatment of opportunistic infections should also be contemplated. ARV treatment can impact on stigma because it changes HIV into a manageable chronic disease, and encourages

disclosure. Workers also need to learn that in general, the chances of a PLWHA infecting other people are much reduced. Thus, it is probable that PLWHAs are treated like any other person. For this initiative to be successful, workers need to be assured that their Aids issues are treated confidentially so that they trust the medical services offered by the company.

The future

Being a quantitative study, this survey has known limitations. Reliance on a self-report questionnaire is problematic as it can be biased by recall and by perceived "social correctness". This is particularly true regarding questioning about sexual related behaviours.

For that, it is suggested that this survey should be complemented with focus group discussions so as to provide qualitative inputs, thus providing a clearer profile of the HIV and Aids-related stigma in the company.

Reducing workforce stigma around Aids is a process that is not easy to measure. For that, it will be difficult to demonstrate the impact of these proposals. Effective monitoring systems are vital for the long-term management of programs. Indicators proposed by Siyam'kela (2003a) for tracking progress programs can be used. The possible list of indicators could include the disclosure rate, the number of known HIV positive people, the degree to which people openly discuss HIV and Aids, and the extent and type of discrimination. This should be coupled with the repetition of the present survey along the same lines, one year after the start of the implementation of the stigma mitigation measures so as to allow the comparing of results.

The findings of the present study should be shared with the company's workforce. This feedback can be used to include workers views as well as those of PLWHAs educators in the planning of interventions that address stigma mitigation.

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ANNEX I

The profile of HIV and Aids-related stigma and discrimination within a company in Maputo

Informed Consent Form for the questionnaire

This consent form will be administered to ANE's employees at different departments in Maputo.

Introduction: As a possible participant in the study, we would like you to know a few things about the research. You are free to ask questions at any time.

Purpose: I am working on a study to find out how to strengthen workplace response to HIV and Aids by reducing HIV-related stigma, and thus enhancing workers' access to the HIV and Aids services offered by ANE to its employees.

Risks and discomforts: The risks to you as a participant in the study are limited. Some of the questions may be personal and sensitive. If at any time you do not want to answer any question, you are not obliged to do so. Confidentiality and privacy will always be ensured. This questionnaire is anonymous and for this, your name will never be used.

Benefits: The results from the study will be used to strengthen ANE's HIV and Aids workplace programs.

Compensation: You will not receive payment for your participation in this study. The ANE management fully supports the implementation of the study, and see this as a means of getting employees to be better informed, and for them to become accessible to quality HIV and Aids services.

Privacy: The information will be collected in a manner that ensures your privacy is not abused.

Right to refuse or withdraw: Before being participating in this study, please understand that your participation is voluntary. You do not need to participate in the research if you do not want to, and you can stop participating at any time.

Do you have any questions? If you have questions later on, you may contact Ricardo Barradas at the Social Unit.

Do you agree to participate in this study?
(1) Agree (2) Disagree

Investigator's statement:

I, the undersigned, have explained to the participant in the language that he/she understands the procedures to be followed in this study and the risks and benefits involved. He/she has agreed to participate in the study.

Date: Name of investigator:

Signature of investigator:

The profile of HIV and Aids-related stigma and discrimination within a company in Maputo

QUESTIONNAIRE

HAVE YOU READ OUT THE CONFIDENTIALITY AGREEMENT IN FULL AND IT HAS BEEN SIGNED?	
001: Interviewer Name	
002: Interview Date (dd/mm/yy)	
003: Checked by Name	
004: Checked Date (dd/mm/yy)	
005: Captured By Name	
006: Captured Date (dd/mm/yy)	

SECTION A: BACKGROUND INFORMATION

No.	QUESTIONS AND FILTERS	ANSWER CATEGORIES	CODES & SKIPS
101	Sex of respondent.	a) Male b) Female	01 02
102	How old were at your last birthday?	a) Age in years b) Don't know	[___|___] 98
103	What is the highest level of education/schooling that you have completed? ONE RESPONSE	a) 1ª-6ª classe b) 7ª-9ª classe c) 10ª-12ª classe d) Universidade e) Nunca andei na escola x) Outro (especificar)_____	01 02 03 04 05
104	Do you have a …. READ OUT CAN INDICATE MORE THAN ONE ANSWER	a) Girlfriend / Boyfriend b) Spouse c) Permanent partner d) None x) Other (specify) _____	01 02 03 04 *To 106*
105	With whom have you had the longest relationship?	a) Girlfriend / Boyfriend b) Spouse c) Permanent partner x) Other (specify) _____	01 02 03
106	How many living children do you have?	a) Number of children	[___|___]
107	How long have you been living continuously	a) No of Years or	[___|___]

	in Maputo?	b) No of Months	[___|___]
108	How many people live in your household (including yourself)?	a) Number of people *(enter raw no.)*	[___|___]
109	Who do you live with? *DO NOT READ* *CAN INDICATE MORE THAN ONE ANSWER*	a) Wife/Husband b) Girlfriend/Boyfriend c) Sister/brother d) Children e) Mother/Father f) Grandparent g) Uncle/Aunt h) Other relative x) Other (Specify) _____	01 02 03 04 05 06 07 08
110	What type of work do you do?	a) Agente Serviço b) Operário c) Auxiliar Administrativo d) Assistente Técnico e) Técnico Profissional f) Técnico Superior x) Outros (especificar)_____	01 02 03 04 05 06 07
111	In which department of ANE do you work?	a) DG b) DA c) DEN d) DER e) DO f) Oficinas x) Other (specify)_____	
112	How long have you been working for this enterprise?	a) Number of months or b) Number of years	[___|___] [___|___]

SECTION B: STIGMA AND DISCLOSURE			
201	Do you know of anyone who has had a blood test for HIV and Aids AND is POSITIVE?	a) Yes b) No c) Don't know.	01 02 98
202	Do you think that it is advisable for people to tell others their HIV and Aids status?	a) Yes b) No c) Don't know	01 02 *To 204* 98
203	Who would be the most appropriate person/people to be informed of someone's HIV and Aids status? DO NOT READ *SINGLE RESPONSE*	a) Spouse / permanent partner b) girlfriend/boyfriend c) Parents d) Close Friend e) Colleague f) Neighbour g) Social worker h) Counsellor x) Other (specify) _____	01 02 03 04 05 06 07 08
204	If a member of your family got infected with HIV and Aids, would you want it to remain a secret?	a) Yes b) No c) Don't know	01 02 98

205	Who would you tell first if you were infected with HIV? *SINGLE RESPONSE*	a) Girlfriend/Boyfriend b) Spouse c) Colleague d) Social worker e) Counsellor f) Friend g) No-one x)Other specify)_____	01 02 03 04 05 06 07 *To 207*
206	How would you go about telling this person about your HIV status?	a) Take him/her to a VCT b) Take him/her to a support group c) Show him/her your results d) Encourage that both of you tested e) Don't know x) Other (specify)_____	01 02 03 04 98
207	Would you feel comfortable to shake hands with a colleague /person whom you know has HIV and Aids?	a) Yes b) No c) Somewhat	01 02 03
208	Would you feel comfortable eating from the same plate with a colleague /person whom you know has HIV and Aids?	a) Yes b) No c) Somewhat	01 02 03
209	Would you feel comfortable to share work tools with a colleague /person whom you know has HIV and Aids?	a) Yes b) No c) Somewhat	01 02 03
210	Would you feel comfortable to share the same toilet with a colleague /person whom you know has HIV and Aids?	a) Yes b) No c) Somewhat	01 02 03
211	Would you feel comfortable to travel in the same vehicle with a colleague /person whom you know has HIV and Aids?	a) Yes b) No c) Somewhat	01 02 03
212	Do you agree or disagree that colleagues/people with HIV and Aids should be separated from others?	a) Agree b) Disagree c) Don't know	01 02 98
213	Do you agree, or disagree, that people who have HIV and Aids do not deserve compassion or support?	a) Agree b) Disagree c) Don't know	01 02 98
214	What kinds of bad treatment do People Living with HIV and Aids (PLHA) and/or their families face? DO NOT READ *CAN INDICATE MORE THAN ONE ANSWER*	a) Isolation b) Verbal abuse c) Physical abuse/violence d) Rumours/gossips e) Rejection f) Ejection from home g) Rejection by community h) Rejection by insurance i) None x) Other (specify) _____	01 02 03 04 05 06 07 08 09 *To 216*
215	Who treats them badly? DO NOT READ	a) Family members b) Neighbours c) Community members d) Health workers	01 02 03 04

	CAN INDICATE MORE THAN ONE ANSWER	e) Young people f) Everyone g) Religious groups h) Colleagues x) Other (specify) _____		05 06 07 08
216	Are families who have lost members to AIDS treated worse, the same, or better than those who have lost a member to other causes?	a) Treated worse b) Treated same c) Treated better d) Don't know		01 02 03 98
217	Do you think PLHA should get the same, more or less health care than someone with another chronic disease/illness?	a) Same b) More c) Less d) Don't know.		01 02 03 98
218	If a colleague is found to be infected with HIV and Aids should he or she continue working?	a) Yes b) No c) Don't know.		01 02 98
219	Is a woman infected with HIV treated better, same, or worse than an infected man?	a) Female treated better b) Female treated same c) Female treated worse d) Don't know.		01 02 03 98
	Please tell me if you agree, disagree, or don't know.	Agree	Disagree	Don't Know
220	A person who has AIDS should not be allowed to work	01	02	98
221	A person who has AIDS should not be allowed to sell food	01	02	98
222	A person should only tell others that they have AIDS when they are sick and have no choice	01	02	98
223	I would be willing to care for a male relative with AIDS in my house	01	02	98
224	It is better to tell others that you have AIDS than hide it, so you can get help	01	02	98
225	AIDS is a punishment for bad behaviour	01	02	98
226	I would be willing to care for a female relative with AIDS in my house	01	02	98
227	If you tell your regular partner that you have AIDS, s/he will leave you	01	02	98
228	If I had AIDS, people would call me names and gossip about me	01	02	98
229	If I had AIDS, people would avoid me.	01	02	98
230	If I had AIDS, my work would fire me	01	02	98
231	If I sit near someone with AIDS, others will think that I have AIDS too	01	02	98
232	People with AIDS should be separated from others	01	02	98